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ROBERT DEBERARDINE ABBOTT LABORATORIES 100 ABBOTT PARK ROAD DEPT. 377/AP6A ABBOTT PARK, IL 60064-6008			EXAMINER COLEMAN, BRENDA LIBBY	
			ART UNIT 1624	PAPER NUMBER
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Please find below and/or attached an Office communication concerning this application or proceeding.

The time period for reply, if any, is set in the attached communication.

Notice of the Office communication was sent electronically on above-indicated "Notification Date" to the following e-mail address(es):

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Office Action Summary

Application No.

10/810,999

Applicant(s)

SCHRIMPF ET AL.

Examiner

Brenda L. Coleman

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-- The MAILING DATE of this communication appears on the cover sheet with the correspondence address --

Period for Reply

A SHORTENED STATUTORY PERIOD FOR REPLY IS SET TO EXPIRE 3 MONTH(S) OR THIRTY (30) DAYS, WHICHEVER IS LONGER, FROM THE MAILING DATE OF THIS COMMUNICATION.

- Extensions of time may be available under the provisions of 37 CFR 1.136(a). In no event, however, may a reply be timely filed after SIX (6) MONTHS from the mailing date of this communication.
- If NO period for reply is specified above, the maximum statutory period will apply and will expire SIX (6) MONTHS from the mailing date of this communication.
- Failure to reply within the set or extended period for reply will, by statute, cause the application to become ABANDONED (35 U.S.C. § 133). Any reply received by the Office later than three months after the mailing date of this communication, even if timely filed, may reduce any earned patent term adjustment. See 37 CFR 1.704(b).

Status

- 1) ☒ Responsive to communication(s) filed on 27 November 2006.
- 2a) ☒ This action is **FINAL**. 2b) ☐ This action is non-final.
- 3) ☐ Since this application is in condition for allowance except for formal matters, prosecution as to the merits is closed in accordance with the practice under *Ex parte Quayle*, 1935 C.D. 11, 453 O.G. 213.

Disposition of Claims

- 4) ☒ Claim(s) 1-26, 41-71 and 73-82 is/are pending in the application.
- 4a) Of the above claim(s) 3-15 and 41-70 is/are withdrawn from consideration.
- 5) ☒ Claim(s) 1, 2, 16-26, 71, 80 and 81 is/are allowed.
- 6) ☒ Claim(s) 73, 76-79 and 82 is/are rejected.
- 7) ☒ Claim(s) 74 and 75 is/are objected to.
- 8) ☐ Claim(s) _____ are subject to restriction and/or election requirement.

Application Papers

- 9) ☐ The specification is objected to by the Examiner.
- 10) ☐ The drawing(s) filed on _____ is/are: a) ☐ accepted or b) ☐ objected to by the Examiner.
Applicant may not request that any objection to the drawing(s) be held in abeyance. See 37 CFR 1.85(a).
Replacement drawing sheet(s) including the correction is required if the drawing(s) is objected to. See 37 CFR 1.121(d).
- 11) ☐ The oath or declaration is objected to by the Examiner. Note the attached Office Action or form PTO-152.

Priority under 35 U.S.C. § 119

- 12) ☐ Acknowledgment is made of a claim for foreign priority under 35 U.S.C. § 119(a)-(d) or (f).
- a) ☐ All b) ☐ Some * c) ☐ None of:
- ☐ Certified copies of the priority documents have been received.
 - ☐ Certified copies of the priority documents have been received in Application No. _____.
 - ☐ Copies of the certified copies of the priority documents have been received in this National Stage application from the International Bureau (PCT Rule 17.2(a)).
- * See the attached detailed Office action for a list of the certified copies not received.

Attachment(s)

- ☐ Notice of References Cited (PTO-892)
- ☐ Notice of Draftsperson's Patent Drawing Review (PTO-948)
- ☐ Information Disclosure Statement(s) (PTO/SB/08)
Paper No(s)/Mail Date _____
- ☐ Interview Summary (PTO-413)
Paper No(s)/Mail Date. _____
- ☐ Notice of Informal Patent Application
- ☐ Other: _____

DETAILED ACTION

Claims 1-26, 41-71 and 73-82 are pending in the application.

This action is in response to applicants' amendment filed November 27, 2006.

Claims 1, 16 and 73 have been amended, claim 72 has been canceled and claims 80-82 are newly added.

Response to Amendment

Applicant's amendments filed November 27, 2006 have been fully considered with the following effect:

1. The applicant's amendments and arguments are sufficient to overcome the 35 USC § 112, first paragraph rejection of claims 1, 2, 16-26 and 71-79, labeled paragraph 3) of the last office action, which is hereby **withdrawn**.
2. With regards to the 35 U.S.C. § 112, first paragraph rejection of claims 76-79, the applicants' remarks concerning claims 76-79 were that the guidance provided on page 5, line 8, through page 6, line 12, describes that the compound of the invention can be favorably provided with another analgesic compound to provide pain relief and treatment of disorders ameliorated by controlling neurotransmitter release. The applicants also stated that the specification details characteristics of classes of suitable compounds, e.g. non-steroid anti-inflammatory agents, opioids, tricyclic antidepressants, and anticonvulsants, as well as providing specific, individual examples of suitable additional active ingredients. However, the specification does not describe in detail the characteristic classes and only mentions four suitable additional active ingredients, such as morphine, aspirin, gabapentin and pregabalin. The applicant's

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specification does not sufficiently define the applicants' metes and bounds of the compounds as claimed herein. The term "non-steroid anti-inflammatory agent", "opioid", "tricyclic antidepressant" and "anticonvulsant" in claims 76-79 are relative terms, which are not defined in the specification. The specification does not provide a standard for ascertaining the requisite degree, and one of ordinary skill in the art would not be reasonably apprise of the scope of the invention. The nature of the composition consisting of the compounds of formula I and an additional active ingredient, which is a non-steroid anti-inflammatory agent, opioid, tricyclic antidepressant or anticonvulsant are not described in the specification as set forth above.

Claims 76-79 are rejected under 35 U.S.C. 112, first paragraph, as containing subject matter which was not described in the specification in such a way as to enable one skilled in the art to which it pertains, or with which it is most nearly connected, to make and/or use the invention, for reasons of record and stated above.

3. The applicant's amendments and arguments are sufficient to overcome the 35 USC § 112, second paragraph rejections of claims 71-73, labeled paragraph 6) of the last office action, which are hereby **withdrawn**.

In view of the amendment dated November 27, 2006, the following new grounds of rejection apply:

Election/Restrictions

4. This application contains claims 3-15 and 41-70 drawn to an invention nonelected without traverse in the reply filed on February 15, 2005. A complete reply to

the final rejection must include cancellation of nonelected claims or other appropriate action (37 CFR 1.144) See MPEP § 821.01.

Claim Rejections - 35 USC § 112

The following is a quotation of the first paragraph of 35 U.S.C. 112:

The specification shall contain a written description of the invention, and of the manner and process of making and using it, in such full, clear, concise, and exact terms as to enable any person skilled in the art to which it pertains, or with which it is most nearly connected, to make and use the same and shall set forth the best mode contemplated by the inventor of carrying out his invention.

5. Claims 73 and 82 are rejected under 35 U.S.C. 112, first paragraph, because the specification, while being enabling for pain, does not reasonably provide enablement for "neuroprotection" and/or "neurodegeneration". The specification does not enable any person skilled in the art to which it pertains, or with which it is most nearly connected, to make and/or use the invention commensurate in scope with these claims. The scope of "neuroprotection" and "neurodegeneration" cannot be deemed enabled. The term "neuroprotection" and "neurodegeneration" covers a broad array of different disorders that have different modes of action and different origins. The term covers such diverse disorders as Alzheimer's Disease; Parkinson's Disease; ALS and variants such as forms of ALS-PDC; Gerstmann-Straussler-Scheinker Disease (GSS); Pick's Disease; Diffuse Lewy Body Disease; Hallervorden-Spatz disease; progressive familial myoclonic epilepsy; Corticodentatonigral degeneration; progressive supranuclear palsy (Steele-Richardson-Olszewski); Huntington's disease; more than a dozen dementias collectively called "frontotemporal dementia and Parkinsonism linked to chromosome 17" (FTDP-17); Tourette's syndrome; Shy-Drager syndrome; Friedrich's ataxia and other spinocerebellar degenerations; Olivopontocerebellar atrophy (OPCA); spasmodic

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torticollis; Striatonigral degeneration; various types of torsion dystonia; certain spinal muscular atrophies, such as Werdnig-Hoffmann and Wohlfart-Kugelberg-Welander; Hereditary spastic paraplegia, Primary lateral sclerosis; peroneal muscular atrophy (Charcot-Marie-Tooth); Creutzfeldt-Jakob Disease (CJD); Hypertrophic interstitial polyneuropathy (Dejerine-Sottas); retinitis pigmentosa; Leber's Disease; and Hypertrophic interstitial polyneuropathy. These exhibit a very broad range of effects and origins. For example, some give progressive dementia without other prominent neurological signs, such as Alzheimer's disease, whereas other dementias have such signs, such as Diffuse Lewy Body Disease. Some give muscular wasting without sensory changes, e.g. ALS, and some do have the sensory changes such as Werdnig-Hoffmann. Some are abnormalities of posture, movement or speech, such as Striatonigral degeneration, and other are progressive ataxias, such as OPCA. Some are linked to tau mutations, such as Alzheimer's disease and FTDP-17, and other such as Parkinson's clearly do not. Some affect only vision such as retinitis pigmentosa. Even within those that fall into the same category of effects, there are often striking differences. For example, Alzheimer's disease and Pick's disease both give progressive dementia without other prominent neurological signs. But the characteristic Alzheimer's neurofibrillary tangles are not seen in Pick's Disease, which has straight fibrils, as opposed to the paired helical filaments of Alzheimer's disease. Pick's Disease gives lobal atrophy, not seen in Alzheimer's disease. There are differences in origins, even with what little is known. Thus, among progressive dementias, CJD is definitely caused by an infectious agent; so far as can be determined, this is not so for Huntington's

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disease. Even among the hereditary disorders, the origins are different. Thus, FTDP-17 comes from chromosome 17, Huntington's disease from 4, and the neurodegenerative disorder that people with Down's syndrome develop later in life is presumably connected in some way to 21.

The great majority of these have no treatment at all, and of those that do, none or virtually none have been treated with such inhibitors as are disclosed here. The great diversity of diseases falling within the "neuroprotection" and "neurodegeneration" category means that it is contrary to medical understanding that any agent (let alone a genus of trillions of compounds) could be generally effective against such diseases. The intractability of these disorders is clear evidence that the skill level in this art is low relative to the difficulty of the task. Further, what little success there has been does not point in this direction.

6. Claims 73 and 82 are rejected under 35 U.S.C. § 112, first paragraph, because the specification, while being enabling for pain, does not reasonably provide enablement for all disorders claimed herein. The specification does not enable any person skilled in the art to which it pertains, or with which it is most nearly connected, to make and/or use the invention commensurate in scope with these claims. The scope of the method claims are not adequately enabled solely based on the treatment of conditions whereto modulation, especially antagonism/inhibition, of the neurotransmitter is beneficial, e.g. as the nicotinic acetylcholine receptor provided in the specification.

In evaluating the enablement question, several factors are to be considered. In *re Wands*, 8 USPQ2d 1400 (Fed. Cir. 1988); *Ex parte Forman*, 230 USPQ 546. The

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factors include: 1) The nature of the invention, 2) the state of the prior art, 3) the predictability or lack thereof in the art, 4) the amount of direction or guidance present, 5) the presence or absence of working examples, 6) the breadth of the claims, and 7) the quantity of experimentation needed.

The nature of the instant invention has claims, which are fused pyrrolidine compounds.

HOW TO USE: Claims 73 and 82 include a method of treating inflammation or substance abuse. Any evidence presented must be commensurate in scope with the claims and must clearly demonstrate the effectiveness of the claimed compounds. The specification does not enable any person skilled in the art to which it pertains, or with which it is most nearly connected, to use the invention commensurate in scope with these claims. The claims of the instant invention call for the treatment of any and all diseases associated with inflammation and substance abuse.

The scope of "treatment of substance abuse" cannot be deemed enabled. The notion that a compound could be effective against chemical dependencies in general is contrary to our current understanding of how chemical dependencies operate. There is not, and probably never will be, a pharmacological treatment for "drug addiction" generally. That is because "drug addiction" is not a single disease or cluster of related disorders, but in fact, a collection with relatively little in common. Addiction to barbiturates, alcohol, cocaine, opiates, amphetamines, benzodiazepines, nicotine, etc all involve different parts of the CNS system; different receptors in the body. For example, cocaine binds at the dopamine re-uptake site. Heroin addiction, for example,

arises from binding at the opiate receptors, cigarette addiction from some interaction at the nicotinic acid receptors, many tranquilizers involve the benzodiazepine receptor, alcohol involves yet another system, etc. All attempts to find a pharmaceutical to treat chemical addictions generally have thus failed.

Where the utility is unusual or difficult to treat or speculative, the examiner has authority to require evidence that tests relied upon are reasonably predictive of in vivo efficacy by those skilled in the art. See *In re Ruskin*, 148 USPQ 221; *Ex parte Jovanovics*, 211 USPQ 907; MPEP 2164.05(a).

Patent Protection is granted in return for an enabling disclosure of an invention, not for vague intimations of general ideas that may or may not be workable. Tossing out the mere germ of an idea does not constitute enabling disclosure. *Genentech Inc. v. Novo Nordisk* 42 USPQ2d 1001.

For a compound or genus to be effective against inflammation generally is contrary to medical science. Inflammation is a process that can take place in virtually any part of the body. There is a vast range of forms that it can take, causes for the problem, and biochemical pathways that mediate the inflammatory reaction. There is no common mechanism by which all, or even most, inflammations arise. Mediators include bradykinin, serotonin, C3a, C5a, histamine, leukotrienes, cytokines, and many, many others. Accordingly, treatments for inflammation are normally tailored to the particular type of inflammation present, as there is no, and there can be no “magic bullet” against inflammation generally. Inflammation is the reaction of vascularized tissue to local injury; it is the name given to the stereotyped ways tissues respond to

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noxious stimuli. These occur in two fundamentally different types. Acute inflammation is the response to recent or continuing injury. The principal features are dilatation and leaking of vessels, and recruitment of circulating neutrophils. Chronic inflammation or "late-phase inflammation" is a response to prolonged problems, orchestrated by T-helper lymphocytes. It may feature recruitment and activation of T- and B-lymphocytes, macrophages, eosinophils, and/or fibroblasts.

The scope of the claims involves all of the thousands of compounds of claim 1. The scope of inflammation includes chronic inflammation caused by infiltration of tissue with mononuclear inflammatory cells. Granulomas are seen in certain chronic inflammation situations. They are clusters of macrophages that have stuck tightly together, typically to wall something off. Granulomas can form with foreign bodies such as aspirated food, toxocara, silicone injections, and splinters.

Otitis media is an inflammation of the lining of the middle ear and is commonly caused by *Streptococcus pneumoniae* and *Haemophilus influenzae*. Cystitis is an inflammation of the bladder, usually caused by bacteria. Blepharitis is a chronic inflammation of the eyelids that is caused by a staphylococcus. Dacryocystitis is inflammation of the tear sac, and usually occurs after a long-term obstruction of the nasolacrimal duct and is caused by staphylococci or streptococci. Preseptal cellulitis is inflammation of the tissues around the eye, and Orbital cellulitis is an inflammatory process involving the layer of tissue that separates the eye itself from the eyelid. These life-threatening infections usually arise from staphylococcus. Hence, these types of inflammations are treated with antibiotics.

Cholecystitis is gallbladder inflammation usually caused by a gallstone that cannot pass through the cystic duct. In those cases, it normally cannot be treated by pharmaceuticals but instead the gallbladder is removed. Cholecystitis without the formation of gallstones, called acalculous cholecystitis, is caused by bacteria such as Salmonella, Staphylococcus, Streptococcus (as part of scarlet fever), and leptospirosis, and thus may be treatable by treating the underlying infectious agent. Acute inflammation of the gall bladder can also arise from typhoid; treatment is with antibiotics.

In gout, joint inflammation is caused by the formation of monosodium urate monohydrate (MSU) crystals within the joint space. Acute attacks of gout are treated with colchicine (to inhibit of MSU-induced chemotactic factor release by PMNs) and after the acute phase with allopurinol to control the blood levels of uric acid. Pseudogout, sometimes referred to as calcium pyrophosphate disease (CPPD), is inflammation caused by calcium pyrophosphate (CPP) crystals. It is treated with nonsteroidal anti-inflammatory drugs, corticosteroids, and colchicine.

Sinusitis is the inflammation of the mucosal lining of one or more sinuses. It commonly accompanies upper respiratory viral infections and in most cases requires no treatment.

Pharyngitis (tonsillitis) is an inflammatory illness of the mucous membranes and underlying structures of the throat (nasopharynx, uvula, and soft palate). The illness can be caused by bacteria, viruses, mycoplasmas, fungi, and parasites, and uncertain causes, especially Streptococcus pyogenes, adenoviruses, influenza viruses, parainfluenza viruses, Epstein-Barr virus, enteroviruses, and Mycoplasma pneumoniae.

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Similarly, Osteomyelitis is the inflammation of bones, generally caused by bacteria (most commonly Staphylococcus Aureus). Fungi or viruses can cause the disease.

Dacryoadenitis, an inflammation of the tear gland, can arise from infectious mononucleosis, mumps, gonorrhea, or influenza. Conjunctivitis (pink eye) is inflammation of the conjunctiva and can be caused by many microorganisms, including staphylococci, Haemophilus influenzae, streptococci, gonococci, and viruses such as adenoviruses. Treatment in all of these cases, when possible, is thus to the underlying infectious agent.

Rheumatoid arthritis is an inflammatory bone disease causing destruction of articular cartilage, in which macrophages accumulate in the rheumatoid synovial membrane. Mediators are cytokines, including IL-1 and IL-6, and IFN- γ .

Pneumonia is an inflammation of the lungs that can be caused by viruses (such as respiratory syncytial, parainfluenza, and influenza), bacteria, fungi, mycoplasmas, rickettsias (especially Q fever), Chlamydia, or parasites. It can also occur as a hypersensitivity, or allergic response, to agents such as mold, humidifiers, and animal excreta, and in such a case would be treated with anti-allergic agents.

Other inflammations in the respiratory system include CF, adult respiratory distress syndrome, asthma, and bronchitis.

Myocarditis is an inflammation of the muscular middle layer of the heart (myocardium). Viruses, bacteria, and noninfectious diseases can cause it. Treatment is primarily supportive e.g. drugs may be used to improve the heart's ability to contract and

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to remove extra fluids from the body. Unless the underlying infectious agent itself is treatable, this inflammation is not itself treated.

Glossitis is inflammation of the tongue. Local causes of glossitis include bacterial or viral infection, mechanical irritation or injury from burns, rough edges of teeth or dental and oral appliances, or other trauma; exposure to irritants (tobacco, alcohol, hot foods, or spices), and sensitization (to e.g. toothpaste, mouthwash, breath fresheners, dyes in candy, plastic in dentures or retainers) anemia and other B vitamin deficiencies, erythema multiform, pemphigus vulgaris, syphilis, and other disorders. It can be inherited. Corticosteroids such as prednisone may be given to reduce the inflammation. Antibiotics, antifungal medications, or other antimicrobials may be prescribed if the cause of glossitis is an infection. Anemia and nutritional deficiencies must be treated, often by dietary changes or other supplements.

Meningitis is an inflammation of the outer covering of the brain and spinal cord. Virtually any known infectious agent can cause it. Thus, if it were caused by *Haemophilus influenzae* or *Neisseria meningitis*, the antibiotic derivative rifampin would be used.

Encephalitis is an inflammation of the brain itself. It is most often caused by a group of arboviruses. Treatment of encephalitis is largely supportive because no specific antiviral agents, except for that which works against herpes simplex virus, are available for therapy.

Hepatitis is an inflammation of the liver, usually caused by viral invasion, notably hepatitis A, B and C, but sometimes Epstein-Barr virus; herpes simplex viruses;

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measles, mumps, and chicken pox viruses; and cytomegaloviruses. Treatment, when possible, is with antivirals. Inflammation of the liver also takes the form of alcoholic hepatitis. Lupoid hepatitis is an autoimmune disorder.

Hemorrhoids are an enlarged or varicose condition of the hemorrhoidal veins and tissues around the anus, either internal or external. Anything that obstructs the free circulation of the blood in the portal system will give rise to hemorrhoids. Constipation, straining at stool, diarrhea, dysentery, rough toilet paper, uncleanness, pelvic tumors, displacement of the uterus and pregnancy are among the most common causes.

There is a series of inflammatory problems directly connected to neutrophil-endothelial cell adhesion (NECA). These include frostbite injury, bacterial meningitis, acute airway inflammation, allograft rejection, hemorrhagic shock, septic shock, ischemia, and reperfusion injuries.

Urethritis is an inflammation of the duct that leads from the bladder to the exterior of the body. It is often due to fecal contamination or irritation due to physical or chemical substances (e.g. introduction of foreign bodies into the urethra, bubble bath, or soap) or gonorrhea. Treatment may simply involve the withdrawal of the offending chemical agent, or the administration of antibiotics, when *Neisseria gonorrhoeae* is involved.

Inflammation can arise from the eruption of teeth in a child (teething).

Inflammation of the nails can arise from chronic paronychia, fungus (especially *Candida albicans*), trauma, impaired circulation, and dermatitis.

Bright's disease (or glomerulonephritis) is inflammation of the glomeruli and the nephrons, the structures in the kidney that produce urine. It usually results from an infection, such as a streptococcal infection, that occurs somewhere else in the body. There is no real treatment beyond relief of the symptoms.

Thyroiditis is an inflammation of the thyroid gland, and takes three forms. Hashimoto's Thyroiditis (chronic lymphocytic thyroiditis) is the most common type of thyroiditis. It is an autoimmune disorder, and treatment is to start thyroid hormone replacement. For De Quervain's Thyroiditis (subacute or granulomatous thyroiditis), treatment is usually bed rest and aspirin to reduce inflammation. Occasionally cortisone and thyroid hormone may be used. Silent Thyroiditis usually arises following pregnancy. Treatment is usually bed rest with beta-blockers.

Regional enteritis (Crohn's disease or ileitis) is an autoimmune disorder, which is associated with the presence of *Mycobacterium paratuberculosis*. It can affect any part of the gastrointestinal tract but most commonly affects the ileum. The inflammation is controlled primarily by regulation of diet, antibiotics if abscesses and fistulas are present, sometimes Prednisone and other corticosteroids, and surgery.

Stomatitis, inflammation of the mouth, and mucositis, inflammation of the mucosa can arise from sources as diverse as *Candida albicans*, dentures, chemotherapy, and radiation therapy to the head, neck or mouth ("Radiation mucositis"). It may be secondary to infection, trauma, systemic diseases or autoimmune mechanisms. These come in many forms, such as aphthous ulcers, Acute Necrotizing Ulcerative Gingivitis i.e. "trench mouth", and Lichen Planus. Herpetiform ulcers treatment has ranged from

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antibiotics, immunosuppressants and yogurt, to Lactobacillus capsules, tetracycline and systemic steroids. Palliative measures include topical anesthetics, Vitamin E, analgesics, and coating agents. Antiviral agents may be used if viral origin is established.

Pancreatitis is inflammation of the pancreas and can arise from abdominal trauma, or the formation of gallstones that obstruct the common bile duct. It can be associated with excessive ingestion of alcohol; with disorders such as cystic fibrosis or. Reye's syndrome; or with scorpion stings. Infectious causes include mycoplasmas, Epstein-Barr viruses, Coxsackie viruses, leptospirosis, hepatitis viruses, mumps, congenital German measles, Ascaris worms, and syphilis. The inflammation per se is generally not treatable. Treatment is usually supportive and consists of the management of pain and intravenous feeding.

Neuroretinitis is inflammation of the retina and optic nerve of the eye ("optic neuritis"). It is often idiopathic. It frequently arises secondary to some kind of infection, such as Hepatitis B, HSV, EBV, influenza A, mumps, Coxsackie B, TB, salmonella, Lyme disease, syphilis, leptospirosis, Histoplasmosis, Toxoplasmosis, toxocara, Sarcoidosis, and cat-scratch disease. Treatment is thus to the underlying cause. For example, diffuse unilateral subacute neuroretinitis (DUSN) arises from nematodes deep in the retina or in the subretinal space. Anthelmintic treatment is then used. When the origin is Toxoplasmosis, then anti-Toxoplasma medications such as Pyrimethamine.

Other eye inflammations include scleritis and episcleritis, inflammation of tissues on the sclera; choroiditis, inflammation of the middle coat (choroid) of the eyeball, and uveitis, which is inflammation of the parts of the eyes that make up the iris.

Gastritis is inflammation to the stomach lining. Atrophic gastritis is characterized by the loss of the stomach cells that are responsible for manufacturing acid, pepsin, and intrinsic factor. This condition occurs in older people or those suffering from *Helicobacter pylori*. Erosive (hemorrhagic) gastritis occurs when shallow ulcers or sores develop on the upper layer of the stomach lining, usually because of the excessive ingestion of a stomach irritant such as aspirin or alcohol.

There can also be mentioned appendicitis, which can occur when a hard piece of stool blocks the opening of the appendix, causing swelling and inflammation.

The great majority of skin problems involve some type of inflammation, such as response to physical injury (e.g. sunburn, ticks, abrasion, or a bee sting), acute allergic contact dermatitis (such as poison ivy), and infections (such as boils and cold sores). Ingrown hairs, or pili incarnati, can cause acute pustular reactions. Cancerous lesions of the skin frequently show some degree of inflammatory response. The inflammation of acne is caused by leakage of sebum and keratin debris outside the distended pilosebaceous duct. The bacillus *Propionibacterium acnes*, which populate the lesions, may also contribute indirectly to this inflammation by metabolizing the sebum to produce irritant fatty acids. Inflammation in skin problems is usually the result of the release of chemical mediators in the skin, notably histamine, peptides (kinins) and fatty acids (prostaglandins and leukotrienes), that are formed enzymatically in response to e.g.

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injury. Medications designed to counteract inflammation in the skin may or may not antagonize the effects of the particular type of mediator involved, if that is known. The inflammation can take many different forms, including redness, (from dilation of blood vessels); heat, (from increased blood flow); swelling (from leakage of fluid from the small blood vessels); whealing reactions (hives, nettle rash, urticaria) in which vascular changes predominate, and pain or itching. Blisters (from enzymes released from inflammatory cells, resident cells of the skin, or blood plasma components) can cause the breakdown of proteins responsible for the structural integrity of the skin, leading to serious inflammatory disorders such as pemphigus. In addition, the affected skin may feel indurated (hardened) because of the deposition of the coagulation protein fibrin and the infiltration by inflammatory blood cells (lymphocytes, histiocytes, and polymorphonuclear leukocytes).

Prostatitis, inflammation of the prostate, comes in several different forms, including those of bacterial origins, and those, which are not, including chronic abacterial prostatitis and asymptomatic inflammatory prostatitis. Certain types of anti-inflammatory agents, such as non-steroidal anti-inflammatory medications (ibuprofen and naproxen) along with muscle relaxants can be used in the non-bacterial cases.

The above list is by no means complete, but demonstrates the extraordinary breadth of causes, mechanisms, and treatment (or lack thereof) for inflammation. Thus, the scope of claims is enormous.

MPEP §2164.01(a) states, "A conclusion of lack of enablement means that, based on the evidence regarding each of the above factors, the specification, at the

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time the application was filed, would not have taught one skilled in the art how to make and/or use the full scope of the claimed invention without undue experimentation. *In re Wright*, 999 F.2d 1557,1562, 27 USPQ2d 1510, 1513 (Fed. Cir. 1993)." That conclusion is clearly justified here and undue experimentation will be required to practice Applicants' invention.

The following is a quotation of the second paragraph of 35 U.S.C. 112:

The specification shall conclude with one or more claims particularly pointing out and distinctly claiming the subject matter, which the applicant regards as his invention.

7. Claim 82 is rejected under 35 U.S.C. 112, second paragraph, as being indefinite for failing to particularly point out and distinctly claim the subject matter which applicant regards as the invention. The following reason(s) apply:

- a) Claim 82 is vague and indefinite in that it does not end with a period indicating the end of the claim.

Claim Objections

8. Claims 74 and 75 are objected to as being dependent upon a rejected base claim, but would be allowable if rewritten in independent form including all of the limitations of the base claim and any intervening claims.

Allowable Subject Matter

9. Claims 1, 2, 16-26, 71, 80 and 81 are allowed. None of the prior art of record or a search in the pertinent art area teaches the compounds, compositions and method of use of the compounds of formula I as claimed herein.

Conclusion

Applicant's amendment necessitated the new ground(s) of rejection presented in this Office action. Accordingly, **THIS ACTION IS MADE FINAL**. See MPEP § 706.07(a). Applicant is reminded of the extension of time policy as set forth in 37 CFR 1.136(a).

A shortened statutory period for reply to this final action is set to expire **THREE MONTHS** from the mailing date of this action. In the event a first reply is filed within **TWO MONTHS** of the mailing date of this final action and the advisory action is not mailed until after the end of the **THREE-MONTH** shortened statutory period, then the shortened statutory period will expire on the date the advisory action is mailed, and any extension fee pursuant to 37 CFR 1.136(a) will be calculated from the mailing date of the advisory action. In no event, however, will the statutory period for reply expire later than **SIX MONTHS** from the date of this final action.

Any inquiry concerning this communication or earlier communications from the examiner should be directed to Brenda L. Coleman whose telephone number is 571-272-0665. The examiner can normally be reached on 9:30-6:00.

If attempts to reach the examiner by telephone are unsuccessful, the examiner's supervisor, James O. Wilson can be reached on 571-272-0661. The fax phone number for the organization where this application or proceeding is assigned is 571-273-8300.

Information regarding the status of an application may be obtained from the Patent Application Information Retrieval (PAIR) system. Status information for published applications may be obtained from either Private PAIR or Public PAIR.

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Status information for unpublished applications is available through Private PAIR only.

For more information about the PAIR system, see <http://pair-direct.uspto.gov>. Should

you have questions on access to the Private PAIR system, contact the Electronic

Business Center (EBC) at 866-217-9197 (toll-free). If you would like assistance from a

USPTO Customer Service Representative or access to the automated information

system, call 800-786-9199 (IN USA OR CANADA) or 571-272-1000.



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